☐ Initial Screening
☐ Reauthorization

MassHealth Home Health Screening Request

Check "Initial Screening" or "Reauthorization" above. Complete only the boxed areas on the front and all of the back and attach a completed HCFA 485 form, or complete the entire form. Please print.

Member Name:_____

Address: _____

_____

DOB:_____

SSN: _____

RID #: _____

Caregiver Name: _____

Rel. to Member:_____

Are caregivers providing care for member? ☐ Yes ☐ No

If yes, specifically describe: _____

_____

_____

_____

_____

CHHA: _____

CHHA RN/PT/OT/ST:_____

Telephone #:_____

Fax #:

Physician Name: _____

Address:_____

_____

Current MassHealth Services: ☐ PCA ☐ ADH
☐ AFC/GAFC ☐ Private Duty Nursing
☐ Other:_____

Diagnoses and dates of onset: _____

_____

_____

_____

Functional Limitations/Activity Level:

☐ Endurance
☐ Speech
☐ Paralysis
☐ Cane
☐ Independent at home
☐ Up as tolerated
☐ Legally blind
☐ Bladder/Bowel
☐ Ambulation
☐ Walker
☐ Assist w/ADLs
☐ Partial weight-bearing
☐ Hearing
☐ Contracture
☐ Wheelchair
☐ Transfers
☐ Bed rest
☐ No restrictions
☐ Dyspnea
☐ Amputation
☐ Crutches
☐ Up w/assist
☐ BRP
☐ Other: _____

Mental Status:

☐ Oriented ☐ Forgetful ☐ Lethargic ☐ Comatose ☐ Disoriented ☐ Agitated ☐ Depressed

Skilled Nursing Need:

☐ Assess CP status
☐ Assess safety
☐ Assess neurological status
☐ Assess diabetic status, prefill insulin syringes
☐ Teach/supervise medication regimen
☐ Medication Profile or 485 form attached
☐ Assess skin integrity
☐ Oxygen
☐ Assess pain and teach/supervise pain control
☐ Assess urinary status, teach/supervise foley catheter care
☐ Administer Vitamin B_{12} Q month
☐ Prefill PO meds
☐ Venipuncture for: _____
☐ Assess wound healing and teach/supervise signs of infection
☐ Wound care: _____
☐ Other: _____

(complete other side)

Summary/Comments:_____

_____

_____

_____

Goals: _____

_____

_____

Home Health Aide Need: (Check all appropriate)

Personal care:

- ☐ Sponge bath/bed/other
- ☐ Shave
- ☐ Skin care/lotion to dry areas/other
- ☐ Nail care—clean/file
- ☐ Food preparation—breakfast/lunch/dinner
- ☐ Peri-care
- ☐ Catheter care/ostomy care
- ☐ Assist with ambulation
- ☐ Assist with adaptive equipment
- ☐ Tub/shower/shower chair
- ☐ Dressing
- ☐ Hair care—groom/shampoo/curl
- ☐ Foot care
- ☐ Medication—remind/assist
- ☐ Feed
- ☐ Toileting—bathroom/commode/bedpan/urinal
- ☐ Turning/positioning/support-in & out of bed
- ☐ Assist with range of motion exercises
- ☐ Mechanical lift
- ☐ Other: _____

_____

Homemaking tasks:

☐ Clean member's room//bathroom/kitchen ☐ Bed-make/change ☐ Laundry ☐ Shopping ☐ Empty trash

Explain why PCHM unable to meet personal care and homemaking needs: _____

_____

_____

_____

Services Requested: (frequency and duration)

Skilled Nursing: _____

Start of Care Date: _____

Home Health Aide:_____

Authorized Signature:_____ Date: _____

This request is for medical necessity only. Payment is still subject to all conditions of the Division of Medical Assistance, including member eligibility, other third-party resources, and program restrictions.